LONGYEAR (H. W.)

Five weeks with Lawson Tait.

FIVE WEEKS WITH LAWSON TAIT.

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During the month of November and a part of December last I had the privilege of being one of the class of four who are present and assist Mr. Lawson Tait in his operations, both at his private hospital at No. 7 Crescent, and at the hospital for women at Sparkhill, Birmingham.

The following is a very brief account of the operations which I witnessed during the five weeks that I was in Birmingham. I shall not attempt to give a full history of each case, as my time will not allow it, but shall try to bring out the salient points of each case, and especially remark upon those in which any of Mr. Tait's peculiar methods were exhibited.

In person, Mr. Tait is of rather striking appearance, being strong and thickset, having a broad, full face, expressive of strength, earnestness and decision. In manner, he is brusque and business-like to a degree while engaged in his professional duties. To friends, outside of business, he can be very affable and entertaining. In conversation, he is as sharp and terse as in his operations, getting at the point in as direct a manner as possible, and scorning circumlocution in one as he does old methods in the other. His success as an operator seems to depend mostly on unusual manual dexterity, coupled with great concentration and rapidity of thought while at work. He never appears to hurry and his motions are always moderate. The secret of the rapidity with which he finishes his operations is evidently due more to the fact that he generally knows exactly what he wants to do and does it with the fewest possible movements, rather than to any rapidity of movement.

During an operation no one else is expected to speak, and he rarely does so. He usually makes what few remarks he does make at the close of the operation. If anyone present is rash enough to suggest anything regarding the operation, or attempt to [redacted] in any way other than that, that he has been told to do he hears from Mr. Tait in terms both terse and emphatic. I never saw him employ any chemicals in the treatment of wounds, either during or after operations, excepting in the dressing of the stump after hysterectomy. He evidently

believes very little in the usefulness of medicines, as was shown, one day by a remark made by him to Dr. Tappey and myself, when he saw us inspecting a list of the prescriptions used in a public clinic that we attended with him once a week. He said: "I use only three drugs—one is water and the other two are as near it as I can get them." He and his assistant cleanse their hands before an operation by first washing them with soap and water, then rinsing them with spirits of turpentine and again with water. His operations are done in the simplest manner possible and with the least variety of instruments and appliances. An ordinary table is used for laparotomies, which seems a little too simple when he douches the abdomen, as the water is then allowed to run over the patient and floor. The anæsthetic most generally used by him was a mixture of sulphuric ether two parts and chloroform one part.

The following reports of cases I take from my note-book:

CASE I.—RECTO-VAGINAL FISTULA AND GRANULAR DEGENERATION OF CERVICAL AND UTERINE MUCOSA.

(At Mr. Tait's private hospital, No. 7 Crescent, November 1, 1890).

The cervical canal having been previously dilated with Tait's dilator and the patient lying on the bed in Sim's position, Mr. Tait proceeded to operate, kneeling on the floor while so doing. The granulations were first removed with Simon's sharp spoon curette, the uterine cavity then rapidly dried with absorbent cotton on wooden applicators (a number of which had been prepared ready for use), and then thoroughly cauterized with the Paquelin cautery. The operation for the fistula was accomplished in about five minutes, and was done by his split flap process. The scissors were first introduced through the vaginal mucous membrane, at the lower angle of the opening, and the recto-vaginal septum split around its circumference to the distance of about one-sixth of an inch from the margin. Then with a Peaslee needle the wound was sutured with one stitch, it being put in in such a manner as to act as a puckering string. The two ends, coming out close together, were tied tightly, thus bringing the split flaps together so as to evert the edges of the vaginal side into the vagina, and the rectal side into the rectum. Sponges were used. No evidence of antiseptic precautions were observed.

CASE II.—LAPAROTOMY FOR CANCER OF RIGHT KIDNEY.

(At No. 7 Crescent, November 3, 1890.)

Woman about forty years of age. Diagnosis was not made until the abdomen was opened and adhesions broken up around

upper part of tumor, when it ruptured and a portion of its contents escaped into the abdominal cavity. Its nature was then evident, and finding, as it was firmly adherent to intestines and liver and other adjacent tissues, that it was impossible to remove it, Mr. Tait applied the wire clamp as far down as possible and cut off the upper part. A pedicle needle was passed through the stump outside the clamp, and the wound sewed up around the clamp and stump. Abdominal cavity was not washed out. Patient died next morning.

CASE III.—ABDOMINAL HYSTERECTOMY FOR UTERINE MYOMA.
(At No. 7 Crescent, November 5, 1890.)

Tumor reached about midway between umbilicus and ensiform cartilage. Abdomen opened by three incisions, the surface of the tumor nicked slightly by the last cut. Incision extended nearly to ensiform cartilage. Corkscrew inserted and tumor lifted and turned out by aid of hand posteriorly. Strong cord clamp put around cervix as low as possible and tightened. Ligatures passed through broad ligaments next to womb and, with a double turn, loosely fastened around the ligaments. An incision was then made about three inches above the clamp entirely around the uterus and through the uterine tissue down to the myoma, and the tumor peeled and turned out with the fingers. The clamp was then slightly loosened, the ligatures already in the broad ligaments made fast, and numerous catch forceps attached to bleeding vessels in the stump. When the bleeding was controlled in this way, the cup-like cavity was thoroughly examined to see if any hæmorrhage was taking place through the cervix (an accident that Mr. Tait said he had happen once by the retraction of the inner tissues of the cervix). The wire clamp was then applied below the cord and the stump transfixed with one double and one single pedicle needle outside the clamp, excess of tissue in stump trimmed off, lint packed over and around the stump and under the clamp, and the whole covered with a mixture of persulphate of iron and glycerine. Adhesive straps, gauze pads and binder completed the dressing. The clamp was to be tightened a little every two hours for several days; the dressing left for two days, then examined and more persulphate of iron used twice daily. In about ten days the stump sloughs off and the cup-shaped cavity is afterwards dressed with red wash until it heals. I saw the patient eleven days after the operation when Mr. Tait lifted off the sloughing end of the stump with the clamp. The patient was in good condition and had had no rise of temperature.

Case IV.—Perineorrhaphy.

(At Woman's Hospital, same date as preceding case.)

Mr. Tait's method is original and he completes the operation in about five minutes. The patient was in an ordinary ward bed, in the lithotomy position, and Mr. Tait operated sitting sideways on a low ottoman. The cutting was all done with a pair of strong scissors, and made in five movements. The first by inserting the narrow and pointed blade deeply into the perineum on the right side, about one inch from the anus, and midway between anus and vulva, and splitting deeply the recto-vaginal septum. The other four cuts are made nearly at right angles with the ends of this one, the two upper ones being about three-quarters of an inch in length and parallel with the lips of the vulva, and the two lower ones about one-half inch long each, and passing down outside the sphincter ani muscle. This makes a broad H shaped incised wound, with the upper sides of the letter a little larger than the lower. The upper and lower flaps were then each grasped by forceps and pulled upward and downward respectively, and a Peaslee needle inserted just *inside* the margin of the skin—not through it—near the anus on the left side, a deep bite taken, brought out at about three-fourths of the depth of the wound, and a bite on the opposte side taken like the first, the needle being brought out close to the margin of the skin, but not including it. Mr. Tait now caught up a number of silk-worm gut sutures and held them in his mouth, and with one of them he threaded the needle and pulled it through. Three or four more sutures were similarly placed, each being taken from the operator's mouth as needed, all tied, and the operation was finished. No superficial stitches were put in the skin. Mr. Tait said that this method of suturing was for the purpose of avoiding the pain caused by the cutting of stitches through the skin, as occurs when put in in the ordinary way. The sutures are usually left in two or three weeks. I saw one of these cases when the stitches were removed, and the result was, in appearance, all that could be desired.

Case V.—Perineorrhaphy.

(At No. 7 Crescent, same date as preceding case).

Being essentially the same as the one described I will not read the notes of it.

Cases VI, VII, VIII and IX.—All Laparotomies.

(On November 7, 1890, the first two at No. 7 Crescent, and the last two at Woman's Hospital).

The first was a large myoma of left ovary. Had been diagnosed as uterine and its true location only known when abdomen was opened. Incision extended from near pubis to two inches above umbilicus. Corkscrew inserted but failed to hold and tumor was turned out with hand. Pedicle quite long, grasped with forceps and ligated with silk, Staffordshire knot, ends cut short with stump and dropped back. Abdominal wound sewed with interrupted silk sutures. Mr. Tait puts these sutures in all in one piece, sewing over and over, then cuts each one off after tying. Patent recovered.

The second operation was the removal of uterine appendages for small uterine myoma. Incision in abdomen one and one-half inches long. Peritoneum was entered by grasping the subperitoneal fat as soon as that structure was reached on each side of the incision with forceps and cutting between. This was repeated until a small opening was made in the peritoneum when he passed in the handle of his knife, as a director, and followed in with one, and then two, fingers, the edges of the peritoneum closing tightly around them. The adhesions resulting from an old salpingitis on one side were broken up and an ovary and a hydrosalpinx brought out between the two fingers. With his other hand he passed a Peaslee needle through the pedicle just below his fingers and tied the Staffordshire knot in a most dextrous manner, without assistance, using the little finger of the engaged hand to hold one end of the ligature. Then still retaining his hold of the ovary, he passed his index finger down to the ligature and cut the pedicle little by little with scissors, watching for bleeding vessels, and snipped the ends of the ligature with the last uncut portion, and allowed the stump to fall back into the abdomen. The appendages on the opposite side were normal, and were rapidly withdrawn, ligated and cut off in like manner.

The third was a case of hematosalpinx. She had been under Skene Keith for some time, and was treated by him with electricity. Mr. Tait said he had no doubt but that the electricity had produced the condition present. Patient had had excruciating pain for a long time in this side. The usual small incision was made. The tube was greatly distended and was ruptured in breaking up adhesions. After removing it with the ovary, in the usual manner, the abdominal cavity was thoroughly flushed with hot water, a glass drainage tube put in and abdomen sewed up. The suction syringe was used and showed considerable bleeding, but this gradually ceased. Directions

were given to use the suction syringe every two hours for two or three days and tube to be removed when no fluid was brought up. Recovered.

The fourth was a cyst of the broad ligament. Abdominal incision one and one-half inches long. Trocar passed along the finger into the sack, and clear watery fluid escaped. When sufficiently emptied the sack was drawn up by canula and finger and grasped with forceps and enucleation accomplished mostly with the fingers. It had, at last, quite a firm attachment and this was ligated, the mass cut off and stump dropped back. A glass drainage tube was passed into the cavity from which the sack had been removed and the abdominal wound sewed up as usual. Recovered.

Case X.—Removal of Uterine Appendages for Uterine Myoma.

(At No. 7 Crescent, November 8, 1890).

Before operating, Mr. Tait said that he was not quite sure of the diagnosis, but that he should open the abdomen, hoping it was myoma, and if so would remove the appendages. If on examination he should find the growth malignant, as some of the symptoms indicated it might be, he should sew up the abdomen and do nothing more. On examination, after making the usual small opening in the abdomen, he said it was undoubtedly a multinodular myoma, and proceeded to remove the appendages as in previous cases. Duration of operation twelve minutes. No drainage tube. Recovered.

Cases XI, XII and XIII.—All Laparotomies.

(At No. 7 Crescent, November 13, 1890.)

The first was a dermoid cyst of left ovary. Had been a patient of Matthews Duncan and just before he died he told her that she had a uterine myoma, and advised permanent separation from her husband. Mr. Tait remarked, after the operation, that if Matthews Duncan had believed in exploratory operations, as he did, the error would not have been made. The diagnosis was not made until the abdomen was opened and the operator had his finger on the tumor. He then said "It is ovarian," inserted a trocar, and no fluid coming away, instantly declared it to be dermoid. He then lifted up sack with canula and finger, grasped it with catch forceps, removed canula and through the opening thrust a pair of strong forceps and pulled out a large mass of hair and debris. The sack was then easily turned out and pedicle ligated, the abdominal cavity douched with hot

water, glass drainage tube inserted and abdominal incision closed. Length of incision two inches. Time of operation fifteen minutes. Recovered.

The next was a case of large multilocular ovarian tumor with numerous adhesions caused by previous tappings. Mr. Tait strongly condemned tapping, and said it was the idiots who did this that caused his mortality to rise from three per cent. in ordinary cases to fifteen per cent. in such as this. Abdominal incision two and one-half inches long. Mr. Tait used a dull pointed trocar, first nicking the tumor slightly with the knife to start its entrance. He remarked that it was much safer to use the dull instruments as he could break up the compartments of the sack with it without danger of injuring anything. He was obliged, however, to insert his hand and break up the sack inside before he could remove it, and while doing so, much of the thick grumous fluid escaped into the abdomen. A number of bleeding vessels at the seat of adhesions had to be ligated. Some adhesions he broke up by grasping the part with two pairs of small catch forceps and tearing between. Close adhesions of the sack to intestine he dissected off with knife. Great amount of hot water used in douching abdomen. Glass drainage tube inserted and wound closed as usual. Recovered.

The third case of the day was a moderate sized ovarian tumor in an old Welsh woman, sixty-eight years old. Incision about an inch long, tumor drained by trocar and pulled out. Pedicle was long and thin and was quickly ligated with a single ligature, cut off and dropped back. No drainage tube. Saw this patient a week afterwards with Mr. Tait, when he took out the stitches and remarked that it was the first time he had seen her since the operation. Time of operation six minutes.

Case XIV.—Gonorrhœal Pyosalpinx.

(At No. 7 Crescent, November 14, 1890.)

The tubes were distended with pus and everything in the pelvis matted together into a solid mass. Adhesions were broken up with two fingers in abdomen and one in vagina, and a good deal of force was evidently used. Pus escaped into abdominal cavity. Much hœmorrhage. When ligating pedicle the ligature cut through a part of it as if it was made of wet paper. Parts grasped further down with forceps, and this also gave way. He then ligated both sides as best he could, and flooded the abdomen with hot water for some time. Bleeding continued. He then put in glass drainage tube, sewed up wound and used the sucking syringe. At first a good deal of

blood came up, but this gradually ceased, and in a few minutes he could obtain but a few drops. He directed the syringe to be used often for several hours. Remarked that this method often controlled some of the worst cases of this kind. She had some peritonitis afterwards, but it was controlled with the free use of saline purges and turpentine enemata, and she recovered.

Case XV.—Infantile Uterus.

(At Woman's Hospital, November 14, 1890.)

The patient had great pain and scanty flow at menstrual periods. Married six years, never pregnant. Incision as usual. Tube on one side very adherent and required considerable manipulation to tear it loose, and was then difficult to tell where the tube ended and the uterus began. Other side was easily removed. Drainage tube inserted. No hœmorrhage. She began to bleed in the night and it continued all night. Wound was opened, but no bleeding points could be discovered to ligate, and forceps were at last put on to each broad ligament. This controlled the flow, but the patient gradually sank and died the next night.

Chse XVI.—Hysterectomy for Œdematous Myoma.

(At No. 7 Crescent, November 15, 1890.

Patient had been treated for a long time with galvanism by a well-known London specialist. Mr. Tait intended to remove the appendages, but finding them bound down by adhesions, concluded to perform hysterectomy instead. Said he thought the adhesion of appendages was due to the galvanism. The corkscrew was inserted but would hold but little. The mass was raised out, however, and a rubber tube ligature tied around the cervical portion, leaving the appendages below it. An incision was rapidly made around the lower portion of the tumor, about one and one-half inches above the ligature, and an attempt made to peel it out. It was found very soft and broke up like an encephaloid cancer. Mr. Tait thought this soft condition due to the electricity. The hysterectomy needles were passed through the stump outside the rubber ligature, the stump trimmed of excess, wound sewed up and dressed as in previous case noted. Recovered.

Case XVII.—Cyst of Broad Ligament.

(At No. 7 Crescent, November 19, 1890.)

Small incision. Contents of cyst evacuated by trocar. Adhesion of omentum and intestines over a large surface. Did not enucleate. Said in such a case there would be too large a raw and bleeding surface left, and he preferred to treat it by ligat-

ing the pedicle, if he could get one. Adhesions were broken up with a good deal of difficulty. Pedicle was very thick, and was ligated by a double ligature, which seemed to include a portion of the walls of the cyst. After cutting off cyst and dropping back stump, a large piece of omentum was found to be oozing over quite an extent of surface. He first removed this with persulphate of iron, but afterwards ligated and cut off the entire mass. Glass drainage tube. Time of operation, forty-five minutes. Recovered.

CASES XVIII, XIX, XX AND XXI.—REMOVAL OF APPENDAGES FOR UTERINE MYOMA.

(At No. 7 Crescent, November 20, 1890.)

Operation simple. Incision one and one-half inches long; no drainage tube; three stitches. Recovered.

Second case the same as the preceding one. Patient quite fat and very anæmic. Had difficulty in bringing up appendages, and had to ligate partly by sense of touch inside the abdomen. Drainage tube was used, as it was thought the pulling might result in some bleeding. Time, twenty-five minutes. Recovered.

Third case the same as the two preceding. Patient very thin, extremely anæmic, and weak from loss of blood. Incision one inch long. Operation very simple. No drainage tube. Two stitches. Time, ten minutes. Recovered.

The fourth case was one of curetting and use of Paquelin cautery, and was treated exactly like the similar case previously noted.

CASE XXII. CONGENITAL ABSENCE OF SPHINCTER ANI WITH MUCH PROTRUSION OF BOWEL.

(At No. 7 Crescent, November 26, 1890.)

Patient twenty-one years of age. The bowel was first drawn down and a row of catch forceps applied to the mucous membrane, encircling the bowel, about two inches from the skin. This ring of mucous membrane was then dissected up from the forceps to the skin and cut off. He then puckered the muscular coat of the bowel transversely by using six or eight deep sutures of silk-worm gut. The edges of the skin were then united to the edges of the mucous membrane above. When I left this patient was doing well, but it was too soon to determine the ultimate result of the operation.

CASE XXIII. LARGE UMBILICAL HERNIA, THE SIZE OF A COCOANUT.

(At No. 7 Crescent, November 27, 1890.)

Had been operated on six months previously by another surgeon. Owing to adhesions, had great difficulty in finding

the ring. Large mass of omental tissue adherent, which was ligated in several places and cut off. Gut kept back by sponges. Edges of ring grasped by catch-forceps, and incision made all around it, splitting it into an upper and lower portion. The split edges were then approximated by the use of silk-worm gut sutures, which were cut short. Skin sewed by an uninterrupted silk suture. Abdomen was very strongly strapped and bandaged. **Result not known, as I left soon after.**

Case XXIV.—Ovarian Tumor.

(At No. 7 Crescent, November 28, 1890.)

Incision three inches long. Sack nicked and dull trocar introduced; cysts within broken up with instrument; fluid thin and rapidly evacuated. Cyst turned out, pedicle small and eight or ten inches long. Ligated and cut off, and abdominal wound sewed and dressed as usual. No drainage tube. Duration of **operation just five minutes. Recovered.**

Case XXV.—A Complication of Troubles in the Pelvis.

(At No. 7 Crescent, November 28, 1890.)

Said to date from an attack of typhoid fever. Tumor in left hypogastrium, pus in urine. Her physician thought she had had an abscess rupture into the bladder. Mr. Tait said he did not believe that could be so, as it was a very unlikely thing to occur. Remarked that, "You can never be 'cock-sure' of what is in a woman's pelvis." Thought that the hard tumor was not a part of the evident disease of the uterine appendages. "However," he remarked, as he made the first incision, "we will soon know all about it." Incision two inches long; introduced finger, and said there was a hard myoma. Inserted corkscrew, and drew it outside. It had a short pedicle, and seemed to come from one of the ovaries. It was pushed to one side and the appendages searched for. Everything in the pelvis was matted together in a firm mass. With two fingers in the abdomen, and one finger of the other hand in the vagina, the right tube, greatly distended, and ovary, were dug out by using great force. While this was being accomplished the distended tube was ruptured, and a good deal of pus welled up. The ligation was done inside of the abdominal incision, and entirely by the sense of touch, and the ovary and tube cut off. The same process of digging and force was applied to the other side, and with the same result excepting that there was a hydrosalpinx ruptured there instead of a pyosalpinx. As this ovary was brought out it was found to be very intimately adherent to a loop of small

intestine. The line of union was very obscure, but was discovered in a rapid and skillful manner, and divided partly by the thumb nail and partly by tearing it between the points of two pairs of small forceps. Only slight hemorrhage followed. After ligating and cutting this away, the pedicle of the myoma was treated in like manner, and the abdomen flushed with hot water. This at first brought out clots and a good deal of purulent matter, but at last came only slightly tinged with blood. A glass drainage tube was inserted and the wound closed. The patient was in bad condition, and beef tea enemata and stimulants were ordered. In answer to questions, Mr. Tait said that this was a specimen of the most difficult cases of this kind. Also, that he did use *great force*, and that "no man who hasn't a good forearm should attempt it." "But what can you do? You must go ahead after you have got into it. The woman would die anyway, so you had better finish it." Five days after the operation, Mr. Martin, Mr. Tait's assistant, who takes care of the patients after operation, told me that for the first three days she did rather badly, but that she had rallied, and temperature and pulse were then normal, courage good, etc., so that I have no doubt but that she recovered.

CASE XXVI.—SMALL MYOMATOUS POLYPI HANGING FROM OS UTERI.

(At No. 7 Crescent, December 1, 1890).

Removed by tortion.

CASE XXVII.—MULTINODULAR UTERINE MYOMA OF MODERATE SIZE IN A WOMAN PAST THE MENOPAUSE.

(At No. 7 Crescent, December 3, 1890).

Was removed because it was causing great pain by pressure on the pelvic viscera. On turning it out, which was accomplished with some difficulty, as it was very irregular in shape and wedged deep down into the pelvis, it was found to reach down into the lower part of the cervix, and looked as though it would be impossible to form a pedicle in the usual way. This was accomplished in the following manner: The rope clamp was placed around the cervical portion and pushed as far down as possible (even then it included part of the tumor) and tightened. A circular incision was then made around the tumor and about its middle, cutting through the uterine tissue down to the fibrous tissue of the tumor, which was then enucleated from the uterine portion below, the clamp being tightened from time to time as the tumor was worked up and out of the cervix. The

after-treatment of the stump was the same as in cases previously mentioned. Patient recovered—or was in a fair way to when I last saw her. In remarking upon this method of "making a pedicle," Mr. Tait said that it was the one used by Keith and kept secret by him for twenty years, and it was this method that enabled him to attain that mortality of seven per cent. He (Tait) discovered it accidentally and not through Keith.

Case XXVIII.—Perityphilitic Abscess.

(At No. 7 Crescent, December 3, 1890).

Opened five years ago and since then a fistulous opening had existed, through which occasionally passed gas, pus and something like concretions. A sound was passed in to a distance of four or five inches and an incision made through abdominal walls and using the sound as a director into the cæcum. He then split the wall of the gut at the opening and sewed it up with silk. Inserted glass drainage tube and closed external wound. Case was doing well December 7.

Case XXIX.—Cyst of Left Broad Ligament.

(Woman's Hospital, December 4, 1890).

Had removed a similar cyst from the right broad ligament of this case six years before. Incision through old wound three inches. Cyst enucleated with very little difficulty after using trocar. No ligatures used. Sac very friable and some fluid escaped into abdominal cavity. Hot sponges placed for a few minutes in cavity from which sac had been taken. Glass drainage tube placed in cavity and wound closed up. Patient doing well December 6.

Case XXX.—Dysmenorrhœa Caused by Narrow Os Uteri.

(At No. 7 Crescent, December 4, 1891.)

Incised cervix and inserted glass stem.